



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DENTISTRY  
(615) 532-3202 or 1-800-778-4123  
[www.Tennessee.gov/health](http://www.Tennessee.gov/health)

## APPLICATION INSTRUCTIONS FOR LICENSURE AS A DENTIST

### I. THE APPLICATION PROCESS

Application, practice, and renewal as a dentist are governed by T.C.A. § 63-5-101, et seq. and Rules 0460-1-.01, et seq.

1. All **application fees are non-refundable.**
2. All documents and fees required to be submitted by you, or which must be requested from the appropriate institutions in the application process, must be mailed directly to:

**Tennessee Board of Dentistry  
First Floor, Cordell Hull Building  
425 Fifth Avenue North  
Nashville, TN 37247-1010**

3. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
4. **We will discuss application status with the applicant or applicant's spouse only. Please inform hospitals, employers, recruiters, referral companies, or insurance companies that application status updates must be obtained from you.**
5. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty 60) days will be closed.**
6. It is recommended that you do **NOT** make arrangements to practice as a Dentist in Tennessee until you are granted a license by the Tennessee Board of Dentistry.
7. **NOTE: If you are applying for a Limited Educational License or Dual Degree (M.D./D.D.S.) licensure, please read the following:**

**Limited License** – This process is applicable to a Dentist who graduated from a non-ADA accredited program with a degree substantially equivalent to either a D.D.S. or D.M.D. degree and has successfully completed a graduate training program in a recognized specialty branch of dentistry from an advanced specialty program accredited by the ADA. This type of license limits the practice location to ADA accredited institutions, dental education programs or in federally-designated health professional shortage areas. Proof of employment to practice in any of these locations is required upon initial application and subsequent renewal of this license. This type of licensure requires a special type of application. Please request this application from our office or download the application from the Board's website at [Tennessee.gov/health](http://Tennessee.gov/health).

**Limited Educational License** - This process is applicable to a Dentist licensed in another state and who will be teaching in a dental educational institute. This type of license limits the practice location to programs offered by the educational institution. Upon termination of faculty appointment, the license is void. This type of licensure requires a special type of application. Please request this application from our Office or download the application from the Board's website at Tennessee.gov/health.

**Dual Degree Licensure** - This process is applicable to a Dentist who is licensed in Tennessee as a Medical Doctor and who possesses an active dental license which is in good standing in at least one (1) other state. You may use this Application for Dual Degree Licensure application. **However**, the supporting documentation is different and you must apply for your specialty certification at the same time you apply for your dual degree license. Please refer to Rule 0460-2-.02 for more information.

Additional certifications or permits that you can submit an application to add to your general dentist license, if you qualify (see Rules 0460-2-.06 and/or 0460-2-.07):

1. Specialty certification
2. Limited Conscious Sedation Permit
3. Comprehensive Conscious Sedation Permit
4. Deep Sedation/General Anesthesia Permit

**IMPORTANT: You must have a license issued by the Tennessee Board of Dentistry in your possession before you may lawfully practice as a Dentist in Tennessee.**

## II. CHECKLIST – USE TO COMPLETE YOUR APPLICATION

**NOTE: All submissions must be executed and dated less than one (1) year before receipt, or the documents will be rejected by the Board.**

- |   | <u>Done</u> |
|---|-------------|
| 1. Tape to the <u>first</u> page of the Application a passport-size photograph of yourself (taken within the last twelve (12) months); <u>then sign your name on the front of the photograph.</u>   | _____       |
| 2. Complete pages 1 through 6 of the Application. Sign page 6 of the Application <u>in the presence of a Notary</u> ; then, mail all six (6) pages to the Board's Office.   | _____       |
| 3. Complete and mail <b>Attachment 1</b> to the institution from which you completed your Dental program to request that an official transcript be mailed <u>directly</u> to the Board of Dentistry.  | _____       |
| 4. If you <b>are</b> or <b>have ever been</b> licensed, certified, registered, or permitted by any state to practice as a Dentist (or any other health care professional), you must complete and mail <b>Attachment 2</b> to each and every state. <b>Attachment 2</b> may be duplicated to accommodate each request.         | _____       |
| 5. Please complete and mail <b>Attachment 3</b> to the American Dental Association to have your National Board scores forwarded <u>directly</u> to the Board of Dentistry.  | _____       |
| 6. Submit two (2) <b>Original</b> letters of recommendation from licensed dental professionals who can attest to your good moral character. These letters <u>must</u> identify the individual(s) as licensed dental professionals, be submitted on the signator's letterhead, and bear the original signature of the author.  | _____       |
| 7. Copy the front and back of your current CPR card and tape the <u>copies</u> to a full- sized sheet of paper. Submit these copies with your 6-page Application to the Board.  | _____       |
| 8. Attach proof of U.S. or Canadian citizenship or evidence of being legally entitled to live in the U.S. (e.g. copy of birth certificate, voter's registration card, naturalization papers, or current visa status.)   | _____       |
| 9. <b>Paperclip a check or money order in the amount of Four Hundred Ten Dollars (\$410) made payable to the "Board of Dentistry" to the front of the Application.</b>  | _____       |
| 10. <b>If any of your answers to the "competency questions" on pages 4 and 5 of the Application were in the affirmative, please submit a separate document to explain the situation.</b> Please read the instructions on page 4 of the Application carefully. You <u>must</u> answer "Yes", "No", or "N/A" to every question. | _____       |

11. If you took the Southern Regional Testing Agency (SRTA) examination within the last five (5) years, your scores were automatically sent to the Board of Dentistry and do not need to be requested from SRTA. If you took the Western Regional Examining Board (WREB) examination, you will need to request that the testing agency send your scores directly to the Board's Administrative office.

**NOTE:** Anyone who took the SRTA or WREB examination **more than five (5) years ago** will need to request your scores be sent directly to the Board's Administrative office, **and** you will be required to appear before the Board for an interview at the next regularly scheduled meeting of the Board (normally January, May and September). To have your scores mailed, please contact SRTA at (757)428-1003 or [www.srta.org](http://www.srta.org), or WREB at (602)944-3315 or [www.wreb.org](http://www.wreb.org). **Tennessee does not accept any state clinical, the Central Regional Testing Agency (CRDTS) or North East Regional Board (NERB) examinations at this time.**

12. Applicants who have failed three (3) times the National Board or any regional examination must successfully complete a remedial course of post-graduate studies at a school accredited by the ADA before consideration for licensure by the Board. The program director of the post-graduate program must provide written documentation of the content of such course and certify successful completion.

13. **A criminal background check is required.** For instructions to obtain a criminal background check, [click here](#) or go to the Noteworthy section of the Board's website.

14. Complete and submit the Practitioner Profile Questionnaire along with your Application. **Your Application file will not be processed for licensure until a completed Questionnaire is received.** You are required by law to keep your profile up-to-date while you maintain an active license. Failure to do so may subject you to disciplinary action.

**IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing**, within thirty (30) days. Failure to abide by this law could effect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.

**TAPE A  
CURRENT, FULL-  
FACE  
PHOTOGRAPH  
(SIGNED BY APPLICANT  
ON THE FRONT  
OF THE PHOTO)  
HERE**



**FOR OFFICIAL USE ONLY**

**FEEES IF APPLYING  
BY SR TA EXAM  
OR DUAL DEGREE**

1201-001	\$ 400
1201-006	\$ 10
	\$ 410

**STATE OF TENNESSEE  
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**APPLICATION FOR LICENSURE AS A DENTIST**

Please complete each question and return the form, supporting documents, and the Four Hundred Ten Dollar (\$410) application fee to the above address.

**PERSONAL INFORMATION**

**PLEASE PRINT IN INK**

Name: \_\_\_\_\_  
Last First Middle Maiden (if not used as your middle name)

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ U.S. Citizen: Yes \_\_\_ No \_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Practice Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

County (TN Applicants Only): \_\_\_\_\_ Phone: Home: ( \_\_\_\_\_ ) \_\_\_\_\_

Gender: (optional-for statistical purposes only) Office: ( \_\_\_\_\_ ) \_\_\_\_\_

Female \_\_\_\_\_ Male \_\_\_\_\_

Have you ever been known by any other names besides what is listed above? Yes \_\_\_ No

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known. \_\_\_\_\_  
\_\_\_\_\_

## EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space. (Send Attachment #1 to the educational institution where you completed your dental program.)

From:	To:	Educational Institution	City, State	Degree Earned	Year Graduated
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____
_____/_____/_____	_____/_____/_____	_____	_____	_____	_____

Please complete your entire employment history starting with the most current position first. Use the back of this page, if you need additional space. (If you have never worked in the Dental profession, list the other positions in which you were employed.)

<u>Company/ Employer:</u>	<u>Address:</u> (Street, City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u>	
				<u>From:</u> Mo./Yr.	<u>To:</u> Mo./Yr.

## CERTIFICATION INFORMATION

List below **ALL** states, countries, or provinces in which you have ever been or are currently licensed, permitted, or certified as a Dentist. Additional pages may be added, if necessary. [Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit.] Use the back of this page if you need additional space. **If this section does not apply, mark N/A.**

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below **ALL** states, countries, or provinces in which you hold or have ever held a license, certification, or permit as a health professional other than a Dentist. [Submit a copy of **Attachment #2** to all such states, countries, or provinces regarding such licensure, certification, or permit.] Use the back of this page if you need additional space. **If this section does not apply, mark N/A.**

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

	YES	NO
1. Are you certified by the National Boards? (This is not required for dual degree.)	_____	_____
2. Have you ever previously applied for a dentist, dental hygiene, or dental assisting license in Tennessee?	_____	_____
3. Are you certified by the Southern Regional Testing Agency (S.R.T.A.)?	_____	_____
4. Are you certified by the North East Regional Board of Dental Examiners (NERB)?	_____	_____
5. Are you certified by the Western Regional Examining Board (WREB)?	_____	_____
6. Are you certified by the Central Regional Dental Testing Service (CRDTS)?	_____	_____

The regional scores are only effective for five (5) years from the date you take the examination. Please indicate below which regional exam you took, the exam site and the date when you successfully completed the examination. (If scores are more than five (5) years old, refer to Paragraph 11, page 3 of the Checklist.)

Regional Exam Taken: \_\_\_\_\_

Exam Site: \_\_\_\_\_

Date Exam Taken: \_\_\_\_\_

# COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnosis (if necessary), exercise reasoned judgments, to learn, and keep abreast of developments in your profession;
  - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disability, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

**QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.**      **YES    NO**

- |    |   |     |     |
|----|---|-----|-----|
| 1. | Do you currently have a medical condition which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?   | ___ | ___ |
|    | a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?  | ___ | ___ |
|    | b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? | ___ | ___ |
| 2. | Do you currently use chemical substances?   | ___ | ___ |
|    | If yes, do they in any way impair or limit your ability to practice dentistry with reasonable skill and safety?   | ___ | ___ |

*[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]*

## COMPETENCY INFORMATION (continued)

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	YES	NO
3. Are you currently engaged in the illegal use of controlled substances?	___	___
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	___	___
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	___	___
5. If you have held or applied for a license or certificate to practice as a Dentist in any state, country, or province, has, it been, or was it ever, denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
7. Have you ever failed a dental examination? (National Boards, regional or state) If yes, how many times have you failed? _____	___	___
8. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	___	___
9. Have you ever applied for and been denied a state or federal controlled substance certificate?	___	___
If you have possessed such a certificate, has the certificate ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
10. Have you ever been rejected or censured by a dental society?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	___	___
b. Have you ever entered into a settlement or had any legal, adverse action brought <u>against</u> you; or	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
12. If you have ever held a license or certificate in ANY health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
13. Are you currently being treated for the addiction to alcohol or drugs?	___	___
14. Are you currently being treated for a psychological condition?	___	___
15. Have you ever been dropped, suspended, expelled, or disciplined by any school or college for any cause?	___	___

**AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application and signed photo, attest to the truth of each statement made in said Application. I further swear that I have read and understand the law and the Rules and Regulations, which were enclosed in the Application packet, and agree to abide by them in the practice as a Dentist in the State of Tennessee.

**I HEREBY:**

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

**RELEASE** to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Dentist.

**AUTHORIZE** the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

**RELEASE** from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for certification.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
**SIGNATURE** **DATE**

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**NOTARY PUBLIC**

Affix Seal Here

My Commission Expires \_\_\_\_\_

# ATTACHMENT # 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TENNESSEE 37243

**TENNESSEE BOARD OF DENTISTRY**  
1-888-310-4650 ext. 25073  
www.Tennessee.gov

## EDUCATION VERIFICATION

**APPLICANT:** Supply the information requested in this box and then mail this entire form to the school at which you completed your Dental program. NOTE: Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

### TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a Dentist in the State of Tennessee. The Board of Dentistry requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address listed below.

Applicant's Full Name: \_\_\_\_\_  
(Last) (First) (Middle/Maiden)

Applicant's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Applicant's Student Identification Number: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

Degree Conferred: \_\_\_\_\_ Date Degree Conferred: \_\_\_\_\_

**Please forward an original graduate transcript bearing the institution's official seal to:**

**Tennessee Board of Dentistry  
227 French Landing, Suite 300  
Heritage Place MetroCenter  
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

# ATTACHMENT #2



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH LICENSURE AND REGULATION  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TENNESSEE 37243

## TENNESSEE BOARD OF DENTISTRY

### ENDORSEMENT FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box, then, mail one (1) form to the licensure board in EACH state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) NOTE: Some states require a fee for providing endorsement information. To expedite your application, you may wish to contact the applicable state(s).

#### To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a (circle one) license or certificate to practice \_\_\_\_\_  
(Profession)  
numbered \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_. The Tennessee  
Board of Dentistry requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the  
Tennessee Board of Dentistry.

\_\_\_\_\_  
Date Applicant's Signature Applicant's typed or printed name

#### To Be Completed by Administrative Office of State Licensure Board:

Name In Full as it appears on License/Certificate or Permit:

\_\_\_\_\_  
(First) (M.I.) (Last)

License/Certificate/Permit Number: \_\_\_\_\_ Profession: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Basis of Issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
(check one) (State)

\_\_\_\_\_ Written Examination \_\_\_\_\_

The License is currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach supporting documentation.

\_\_\_\_\_  
Authorized Signature Title Date

Please mail directly to: **Tennessee Board of Dentistry** State Seal  
**227 French Landing, Suite 300**  
**Heritage Place MetroCenter**  
**Nashville, TN 37243** \_\_\_\_\_  
State

# ATTACHMENT # 3



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
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DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TENNESSEE 37243

## TENNESSEE BOARD OF DENTISTRY

### NATIONAL BOARD EXAMINATION VERIFICATION

Please complete the top portion of this form, attach a **MONEY ORDER OR CERTIFIED CHECK** in the amount of **Fifteen Dollars \$15.00** MADE PAYABLE TO THE AMERICAN DENTAL ASSOCIATION, and mail it to the address below.

Send to:

DEPARTMENT OF TESTING SERVICES  
AMERICAN DENTAL ASSOCIATION  
211 EAST CHICAGO AVENUE, SUITE 1846  
CHICAGO, IL 60611

### TO BE COMPLETED BY APPLICANT (PLEASE PRINT IN INK)

Dear National Board Official:

I am applying for a license to practice as a Dentist in the State of Tennessee. The Tennessee Board of Dentistry requires that a copy of my scores be **forwarded directly to their** office by the National Boards.

Applicant's Name \_\_\_\_\_  
(First) (M.I.) (Last)

Social Security No.: \_\_\_\_\_ - - Date National Certified \_\_\_\_\_

Name of Institution from which you graduated: \_\_\_\_\_

Date you graduated from the Dental Program: \_\_\_\_\_

Year of Birth: \_\_\_\_\_

### PLEASE MAIL SCORE VERIFICATION DIRECTLY TO:

TENNESSEE BOARD OF DENTISTRY  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METROCENTER  
NASHVILLE, TN 37243

WO/G6018127/BD



**TENNESSEE DEPARTMENT OF**

**HEALTH**

**MANDATORY**

**PRACTITIONER**

**PROFILE QUESTIONNAIRE**

**PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq.,  
LAWS OF TENNESSEE**

**FOR**

**LICENSED HEALTH CARE PROVIDERS**

## FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: <http://tennessee.gov/health>.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

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## SECTION I: GENERAL INSTRUCTIONS

- ▶ Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.
- ▶ Incomplete or illegible profiles will be returned to the provider for resubmission.
- ▶ Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.
- ▶ Provide only information for the previous ten (10) years where indicated on the questionnaire.
- ▶ Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.
- ▶ **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- ▶ You may have completed a similar questionnaire for another state’s licensing board. If so, Tennessee law still requires you to complete and submit this form.
- ▶ If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.

- ▶ **Mail the completed ORIGINAL profile questionnaire within thirty (30) days of its receipt by the provider to:**

**Healthcare Provider Information Manager  
Tennessee Department of Health  
Division of Health Related Boards  
227 French Landing, Suite 300  
Heritage Place Metro Center  
Nashville, TN 37243  
1-800-778-4123  
Local - (615) 532-3202**

- ▶ **Keep a copy of the questionnaire for your records.**

## ✓ CHECKLIST

Before you mail your questionnaire:

- Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?
- Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?
- Have you retained a copy of your signed questionnaire?

## SECTION II:

# COMPLETING THE PROFILE QUESTIONNAIRE

### QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

### COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the “Does not apply” box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

### **I. PRACTITIONER DATA**

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in “N/A” for practice address.

### **II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING**

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

### **III. SPECIALTY BOARD CERTIFICATIONS**

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

#### IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

#### V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

#### VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

**If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of**

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

## **VII. CRIMINAL OFFENSES**

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

## **VIII. LIABILITY CLAIMS**

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. **JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED.** To find out the threshold amount established by your board, consult your board's web page at [www.state.tn.us/health/](http://www.state.tn.us/health/) or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

## **IX. OPTIONAL INFORMATION**

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_  
Profession \_\_\_\_\_

SECTION III:

**HEALTHCARE PROVIDER INFORMATION MANAGER  
TENNESSEE DEPARTMENT OF HEALTH  
DIVISION OF HEALTH RELATED BOARDS  
227 FRENCH LANDING, SUITE 300  
HERITAGE PLACE METRO CENTER  
NASHVILLE, TENNESSEE 37243**

<b>I. PRACTITIONER DATA</b>		
A.	PROFESSIONAL LICENSE NUMBER: _____	PROFESSION: _____
B.	SOCIAL SECURITY NUMBER: _____ <b>(This will not be published as part of the profile or website).</b>	
C.	NAME (INCLUDE MAIDEN AND ON 2 <sup>ND</sup> /3 <sup>RD</sup> LINES ANY ALIASES, IF APPLICABLE):	
	CURRENT NAME:	
	_____ (LAST)	_____ (FIRST) _____ (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)
	FORMER NAME(S):	
	_____ (LAST)	_____ (FIRST) _____ (MIDDLE)
	_____ (LAST)	_____ (FIRST) _____ (MIDDLE)
D.	MAILING ADDRESS:	
	_____ (STREET AND NUMBER)	
	_____ (CITY)	_____ (STATE) _____ (ZIP CODE)
	PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).	
	_____ (PRACTICE NAME)	
	_____ (STREET AND NUMBER)	
	_____ (CITY)	_____ (STATE) _____ (ZIP CODE)
E.	TELEPHONE: (_____) _____ <b>(This will not be published as part of the profile or the web site).</b>	
F.	LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.	
	1. _____	
	2. _____	
G.	SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:	
	1. _____	
	2. _____	

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_  
 Profession \_\_\_\_\_

**II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING**

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_  
 Profession \_\_\_\_\_

**III. SPECIALTY BOARD CERTIFICATIONS**

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES  NO

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

**IV. FACULTY APPOINTMENTS**

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES  NO

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES  NO

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

**V. STAFF PRIVILEGES**

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES  NO

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
------------------	------------

1.	_____
2.	_____
3.	_____
4.	_____
5.	_____

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_  
 Profession \_\_\_\_\_

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES  NO   
 If "YES", list each plan in which you currently participate:

Name of TennCare Plan

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**VI. FINAL DISCIPLINARY ACTION (See Instructions)**

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES  NO

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
-------------	------	--------------------------	-----------------------

1. _____	_____	_____	_____
_____		_____	_____
_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2. _____	_____	_____	_____
_____		_____	_____
_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

3. _____	_____	_____	_____
_____		_____	_____
_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

Practitioner's Name \_\_\_\_\_ License # \_\_\_\_\_  
 Profession \_\_\_\_\_

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES  NO

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

3.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES  NO

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.	_____	_____	_____
	_____		_____
	_____		_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

2.	_____	_____	_____
	_____		_____
	_____		_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

3.	_____	_____	_____
	_____		_____
	_____		_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES  NO

Practitioner's Name \_\_\_\_\_ License# \_\_\_\_\_  
 Profession \_\_\_\_\_

**VII. CRIMINAL OFFENSES (See Instructions)**

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s):		YES <input type="checkbox"/> NO <input type="checkbox"/>
DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1. _____	_____	_____
If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____	_____	_____
If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____	_____	_____
If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

**VIII. LIABILITY CLAIMS**

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1. _____	_____
2. _____	_____
3. _____	_____

**IX. OPTIONAL INFORMATION**

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

TITLE	PUBLICATION	DATE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

\_\_\_\_\_  
 (Signature of Provider)  
 YB/G6019027/RTK-ms.70

Date: \_\_\_\_\_